Arnold Schwarzenegger, Governor
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IN REPLY REFER TO
FILE NO: 933 0338

February 5, 2004

FINAL REPORT

Terry G. Mack, CEO
San Joaquin County Health Commission
1550 W. Fremont St., Suite 200
Stockton, CA 95203-2643

RE: ROUTINE EXAMINATION OF THE HEALTH PLAN OF SAN JOAQUIN

Dear Mr. Mack:

Enclosed is the Final Report of the routine examination of the fiscal and administrative affairs of San Joaquin County Health Commission (the "Plan"), conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on December 03, 2003. The Department received the Plan's response on January 20, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's January 20, 2004 response, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its January 20, 2004 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter.

If there are any questions regarding this report, please contact me.

Sincerely,

Richard Martin
Supervising Examiner
Office of Plan Oversight
Division of Financial Oversight

cc: Paul A. Antigua, Controller HPSJ
Mark E. Wright, Chief, Division of Financial Oversight
Steve Goby, Counsel
Richard L. Murdock, Examiner
Gil Riojas, Examiner

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

SAN JOAQUIN COUNTY HEALTH COMMISSION

FILE NO.: 933 0338

DATE OF FINAL REPORT: FEBRUARY 5, 2004

SUPERVISING EXAMINER: RICHARD MARTIN

EXAMINER-IN-CHARGE: GIL RIOJAS

SAN JOAQUIN COUNTY HEALTH COMMISSION
BACKGROUND INFORMATION

Date Plan Licensed:	January 30, 1996
Organizational Structure:	The Health Plan of San Joaquin, a public agency created by the County Board of Supervisors in January 1995, is a component unit of the county. San Joaquin became Knox-Keene licensed on January 30, 1996 and began operations on February 1, 1996. The Plan was created under the two-plan model pursuant to the California Welfare and Institutions code Section 14087.31.
Type of Plan:	Full Service.
Provider Network:	The Plan has contracted with a number of individual primary care physicians and specialists and also hospitals. Agreements are typically for indefinite periods of time ("evergreen") and contain termination clauses and risk sharing provisions.
Plan Enrollment:	A total of 65,415 enrollees were reported for the quarter ended September 30, 2003. 57,046 were reported as Medi-Cal and 8,369 as Healthy Families.
Service Area:	San Joaquin County.

FINAL REPORT OF A ROUTINE EXAMINATION OF SAN JOAQUIN COUNTY HEALTH COMMISSION

This is the Final Report of a routine examination of the fiscal and administrative affairs of San Joaquin County Health Commission (the "Plan"), conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (b) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on December 3, 2003. The Department received the Plan's response on January 20, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's January 20, 2004 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited examination of the financial report filed with the Department for the quarter ended June 30, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Other Issues

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

At June 30, 2003, the Plan was in compliance with Financial Reporting requirements of Section 1384, 1345(s) and Rule 1300.45(q). Our routine examination resulted in no material adjustments or reclassifications to the financial report filed with the Department. No response to this section was required from the Plan.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

At June 30, 2003 the Plan was in compliance with the TNE requirements of Rule 1300.76. No response to this section is required from the Plan. A copy of the Plan's financial statements including the TNE calculation can be obtained at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search.asp and selecting San Joaquin County Health Commission on the first drop down menu. No response to this section was required from the Plan.

Section III. COMPLIANCE ISSUES

A. PROVIDER CONTRACTS

Rule 1300.67.8 (b) requires provider contracts held by the plan shall require that the provider maintain such records and provide such information to the plan or to the Director as may be necessary for compliance by the plan with the provisions of the Act and rules thereunder, that such records will be retained by the provider for at least two years, and that such obligation is not terminated upon a termination of the agreement whether by rescission or otherwise.

Section 1379 (b) states, no contracting provider, agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the plan.

Our review of a sample of provider contracts disclosed the following:

- Daemon Medical Group contract does not make all books, records and papers available for inspection specifically by the Department for a term of at least two years. The contract also does not state an obligation is not terminated upon termination of the agreement whether by recession or otherwise, nor does it prohibit the provider from maintaining any action at law against a subscriber or enrollee to collect sums owed by the Plan.

- Delta Radiology Medical Group, Inc. contract does not make all books, records and papers available for inspection specifically by the Department for a term of at least two years. It also does not state an obligation is not terminated upon a termination of the agreement whether by recession or otherwise.

The Plan was required to file with the Department evidence that contracts are in compliance with Section 1379 and the enrollee is not at risk for services. The Plan was to also provide evidence that contracts are in compliance with Rule 1300.67.8(b).

In its response, the Plan stated provider contracts were reissued September 1, 2003 that meet the requirements of Rule 1300.67.8(b) and Section 1379(b) and that all provider contracts meet these requirements. In addition, the Plan submitted Sections 7.9.3 and 8.2 of its standard provider contract updated September 1, 2003 to demonstrate compliance.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required by the Department.

SECTION IV. OTHER ISSUES

FINANCIAL STATEMENT REPORTING

CLAIMS PAYABLE-REPEAT DEFICIENCY

The instructions for filing Plan financial statements electronically, require those claims that have been received but not paid be reported on Report 1 – Part B, Line 3. Rule 1300.77.4 requires every plan to institute procedures whereby all claim forms received for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim.

The previous routine examination disclosed the Plan had not been including "claims received but not entered into the system" in the Claims Payable reported on Report 1 – Part B, Line 3. Based on our review of claims payable it has been determined the Plan continues to be noncompliant with the Department's financial reporting instructions and Rule 1300.77.4.

The Plan was required to provide assurance that in the future Claims Payable would be reported correctly on Report 1 – Part B Line 3 of the financial statements filed with the Department.

The Plan was also required to describe the procedures implemented that enable the Plan to accurately determine the dollar amount of claims that have been received but not yet paid as of the balance sheet date. The response was to include an explanation of why the Plan did not adhere to the corrective action indicated in its response to the Department's previous routine examination.

The Plan's response stated that beginning with the quarter ended December 31, 2003, the Plan will be correctly reporting Claims Payable on Report 1-Part B line 3of the financial statements filed with the Department.

The Plan stated in the past they had difficulty capturing and reporting claims received but not yet in the system. The Plan was unable to adhere to policy of reporting claims received but not yet in the system because of their inability to properly reflect the inventory in a report format that would satisfy

auditing of these claims. The Plan stated the reasons for this was due to the volume of claims in the queue and lack of reporting that allowed for those claims to be tracked and audited.

The Plan also stated in May 2003 a Claims Manager was hired to evaluate and re-engineer the claims shop and its processes. This has resulted in a lower backlog of claims and better inventory accountability. Claims received by the Plan are logged and tracked by Julian date and batch type. This gives the Plan the ability to price and categorize these funds from IBNR to claims payable. These claims on the shelf are now reported to the Finance Department and based on historical experience of billed-to-paid, these claims are estimated and re-classed from IBNR to the claims payable section of the balance sheet. The Claims Manager is responsible for continued report development of all claims inventory and to ensure claims are being audited.

The Department finds that the Plan's compliance efforts are responsive to the corrective actions required by the Department.